PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's complete name_____ Age_____ Birth Date_____

Name prefer to be called_____ Patient SSN_____

If patient is a minor, use parent's or guardian's names and information_____

P.O. Box_____ City_____ Zip_____

Residence add_____ City_____ Zip_____

Cell Ph #_____ Residence Ph#_____ Business Ph #_____

Email_____ In order of preference to confirm appointments _____Email _____Text _____Phone

Employed by_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse's Name_____

Name of parents or next of kin **not living with you**_____ Relationship_____

Complete address_____ Res/Cell Ph #_____

Whom may we thank for referring you?_____

Circle any others: Friends Y N Sign or location Y N Staff Y N Newspaper or mailer Y N Office reputation Y N

Yellow Pages Y N ☐ Dex ☐ Yellow Book ☐ Names & Numbers

Purpose of this appointment_____

Please complete the following information if someone other than the patient is responsible for this account.

Complete name_____ Birth date_____

Employed by_____ SSN_____

Business address_____ Bus. Ph #_____

PREFERENCE OF PAYMENT

☐ Cash, Check, Credit or Debit card on day of Treatment

☐ Prepayment discount

☐ Outside financing plan

☐ Other_____

Dental Insurance (company name)_____

Insurance Group #_____

Name & Subscriber ID# #_____

TERMS AND CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment. Our office will help you prepare insurance forms to assist in making collections from your insurance companies and will credit such collections to your account. However, we can not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days. If the insurance payments are denied or delayed past 60 days by your carrier, it becomes the patient's responsibility to pay the bill and personally pursue the insurance carrier.

In consideration of the professional services provided to me, or my dependents, I agree to pay for these services to the Doctor, or his assignee, at the time said services are rendered. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you, or your assigns, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient, upon approval of prescribed treatment by patient or parent.

HIPAA form presented (initial)_____

Signature_____ **Date**_____

Continued on other side

HEALTH QUESTIONNAIRE

Please answer each question. Circle **Yes** or **No** where applicable. Check applicable boxes.

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Physician's name_____ Last examination_____
3. Have you ever had any serious illness or operation? ..... Yes No

   If so, what illness or operation?_____
4. Are you taking any drugs or medication? ..... Yes No

   If so, what?_____
5. Do you use tobacco products? .....Yes No Marijuana? .....Yes No
6. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Local Anesthetic ☐ Pain Pills ☐ Other..... Yes No

   If other, what drugs?_____
7. Are you sensitive or allergic to ☐ Latex ☐ Plastics ☐ Metals such as jewelry..... Yes No
8. Do you have, or have you had, any of the following: (Please check ✓ known conditions) .....

☐ Heart Ailment	☐ Tumors or Radiation Treatment	☐ Stroke
☐ High Blood Pressure	☐ Sinus Trouble or Allergies	☐ Glaucoma
☐ Diabetes	☐ Asthma or Hay Fever	☐ Canker Sores, Herpes or Cold Sores
☐ Excessive Bleeding	☐ Head Injuries or Seizures	☐ Joint Replacement
☐ Rheumatic Fever	☐ Stomach Ulcers	☐ Osteoporosis, Bisphosphonates like Fosamax
☐ Kidney Disease	☐ Epilepsy	☐ Other _____

9. Do you have, or have you ever had or been exposed to AIDS, Hepatitis, or Liver Disease?..... Yes No
10. Are you pregnant? If so, how many months? ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No

DENTAL HISTORY

1. Present or previous dentist's name_____ Address_____
2. Reason for change? Moved_____ Other_____
3. Your best dentist ever was special because_____

   _____
4. Have you ever had any unfavorable reaction from a local anesthetic or previous dental treatment?..... Yes No

   If so, explain_____
5. Are you happy with your teeth and smile? ..... Yes No
6. If you could change anything about your teeth, what would it be?_____
7. Are you concerned with losing teeth in your lifetime? ..... Yes No
8. Have you ever been told or suspected you had gum disease?..... Yes No
9. Would you like information on new products and techniques to help with breath odor? ..... Yes No
10. How long since your last dental treatment?_____
11. How long since your last dental x-ray?_____

    Full mouth (20 films)?_____
12. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderate ☐ Extremely

I have listed all health problems to the best of my knowledge.

SIGNATURE_____ DATE_____